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FISCAL IMPACT STATEMENT

LS 6657
BILL NUMBER: HB 1325

NOTE PREPARED: Apr 3, 2005
BILL AMENDED: Mar 31, 2005

SUBJECT: Medicaid Prescription Drugs.

FIRST AUTHOR: Rep. Becker
FIRST SPONSOR: Sen Server

BILL STATUS: CR Adopted - 2nd House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: (Amended) This bill extends the Prescription Drug Advisory Committee (Committee) and the members' terms to December 31, 2007. The bill requires the Committee to make recommendations before September 1, 2005, to the Secretary of the Office of the Secretary of Family and Social Services (Secretary) and the Governor concerning redesigning the Prescription Drug Program (Program) to not conflict with the federal Medicare prescription drug benefit program. The bill allows the Secretary to: (1) implement the Committee's recommendations; (2) complete federal applications; and (3) enroll eligible individuals in the state program and the federal Medicare prescription drug benefit.

This bill also allows the Office of Medicaid Policy and Planning to provide a prescription drug benefit in the Medicaid risk-based managed care program. It allows a managed care provider contract or provider agreement to include a prescription drug program. The bill establishes the Mental Health Quality Advisory Committee. It also allows the Office to place restrictions on certain prescription drugs under specified circumstances.

The bill also requires the Office of Medicaid Policy and Planning to report information related to the activities of the Mental Health Quality Advisory Committee. The Office is also required to report to the Select Joint Commission on Medicaid Oversight information regarding the transition of the aged, blind, and disabled population to a risk-based managed care program..

Effective Date: (Amended) Upon passage; July 1, 2005.

Explanation of State Expenditures: *Prescription Drug Advisory Committee (Summary):* The fiscal impact

of this provision would consist of two parts: (1) travel expenses related to the committee meetings; and (2) the impact of the recommendations of the Committee are limited to the amount of funding available in the budget. Therefore the fiscal impact of this provision would be dependent upon the amount of funding made available to the program in the biennial budget.

Background on Prescription Drug Advisory Committee: This bill would extend the expiration date for the Prescription Drug Advisory Committee by two years to December 31, 2007. (The Committee's authority expires on December 31, 2005, under current statute.) The Committee consists of 11 members appointed by the Governor and 4 nonvoting legislative members. Expenses incurred by the lay members of the Committee are to be paid from the Indiana Prescription Drug Account, funds which are appropriated from the Tobacco Master Settlement Agreement Fund. Expenses of the four legislative members are to be paid from funds appropriated to the Legislative Council from the state General Fund. Committee expenses are estimated to fall within the amount allocated for legislative interim study committees of $8,000 annually.

The Committee is required to make program design recommendations to coordinate the Indiana Prescription Drug Program (HoosierRx) with the recently enacted Medicare prescription drug benefit. The Committee is further charged with ensuring the program maximizes federal benefits while not duplicating them. The Committee is to submit their recommended changes to the Governor and the Office of the Secretary of the Family and Social Services Administration before September 1, 2005, for program changes related to the Medicare Part D prescription drug benefit which is effective January 2006. The Committee is to make recommendations in a manner that would expend, but not exceed, the Indiana prescription drug program budget.

(Revised) *Mental Health Drug Coverage Under Risk-Based Managed Care (Summary):* This bill would prohibit risk-based managed care (RBMC) providers from requiring prior authorization for mental health-related drugs if a prescription drug benefit is included in the risk-based managed care program operated by the Office of Medicaid Policy and Planning (OMPP) in the Medicaid and CHIP programs. OMPP reports that while the managed care organizations currently experience 10% lower mental health drug costs than that experienced in the primary care case management program, exceptions allowed in the bill should result in minimal fiscal impact to the managed care contracts. The bill also establishes the 7-member Mental Health Quality Advisory Committee. FSSA reports that the expenses associated with the committee will be covered within the existing level of appropriations.

Prescription Drug Carve-out from Risk-based Managed Care: The bill would also allow Medicaid to exclude all prescription drugs in the covered services for RBMC providers and to provide the prescription drug benefit under the fee-for-service claims processing system. If OMPP decided to pursue this option, actuarial estimates indicate the annual cost of the provision could be $14.8 M for FY 2006 (representing $5.6 M in state funds) and $17.3 M for FY 2007 (representing $6.5 M in state funds).

Any increase or decrease in costs to the managed care organizations (MCOs) occur within the capitated managed care contracts. The increased cost does not represent a direct savings or cost to the state since the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care. Increased costs to the state are reflected only to the extent that the increased risk-based managed care costs would be passed through to the state in the negotiated rates. Rate adjustments generally occur in January.

Mental Health Quality Advisory Committee: The bill also establishes the 7-member Mental Health

Quality Advisory Committee. Members of the Committee who are not state employees are entitled to a per diem and reimbursement of travel expenses. The total expenses associated with the Committee would be dependent upon the home locations of the appointed members and the number of times the Committee meets. Committee expenses are estimated to fall within the amount allocated for legislative interim study committees of $8,000 annually. FSSA reports that the expenses associated with the Committee will be covered within the existing level of appropriations.

Additional Claims Processing: The Office does not currently process drug claims for risk-based managed care clients in the fee-for-service claims processing system. If the Office decided to discontinue the RBMC client drug claims within the contracts of the MCOs, it would increase the number of claims that would be processed and paid by the contractor that processes the fee-for-service claims. OMPP reports that under the current contract, the additional volume of claims processing would cost $167,400 each year at a minimum. However, the contract processing fees are based on anticipated volume, and OMPP reports it is possible the contractor would not agree to this increase in claims without increasing their processing thresholds and the rate. A contract amendment could result in the claims processing cost increasing by approximately $1.044 M in FY 2006, representing an increase in spending of $522,000 in state General Funds. These estimates are based on available shadow drug claims data for Medicaid MCOs, which is incomplete for the 294,149 individuals enrolled in risk-based managed care during FY 2004. Consequently, the estimates are probably conservative. Medicaid administrative expenses are matched at 50% by the federal government.

Renegotiating MCO Contracts: If the prescription drug component of the MCO contracts were eliminated, it would require at a minimum that the capitation amounts paid per member per month would have to be recalculated and the contracts amended. If the MCOs would not agree to such a significant change in the terms of their participation, it is possible that the managed care contracts would need to be reprocured; a process that takes about a year to complete.

MCO Management of Drug Expenditures: There are two components to the cost of pharmaceuticals purchased: what the purchaser actually pays for the various products (a negotiated price); and the actual mix of products purchased (prescribing management practices).

Negotiated Prices: Medicaid generally pays the lower of several defined costing options, one of which is the Average Wholesale Price (AWP) less 13.5% for brand-name drugs and AWP less 20% for generic drugs, plus a $4.90 dispensing fee. Without access to the MCOs' actual cost of drug products, it would be difficult to determine whether the Medicaid cost for drugs would be higher or lower than what the MCOs currently pay.

Prescribing Management: While the MCOs' costs for drugs are unknown, it is clear that MCOs have other effective tools they use to manage the mix of products they buy (or don't buy), and consequently, the total dollars spent on pharmaceuticals. MCOs use preferred drug lists, as does the Medicaid program. However, MCOs also have strong relationships with their primary care providers (PMPs) and encourage the PMPs to write scripts for preferred drugs. The MCOs can also offer bonuses based on prescribing practices of the PMPs. The MCOs also have strong quality and utilization management controls that help them manage pharmacy costs.

OMPP reports that the MCOs' total pharmacy expenditures on a per member per month basis are consistently and significantly lower than the similar population in the more loosely managed fee-for-service-based Primary Care Case Management (PCCM) program. RBMC self-reported pharmacy costs average around $20 to $25 per member per month, while the PCCM claims average $35 to $40 per member per month. If the MCO

pharmacy management controls are removed, costs for the 294,149 enrolled Medicaid MCO participants could potentially increase to average the PCCM experience. The Medicaid actuary has estimated the cost of "carving out" the prescription drug component from the managed care contracts could be $13.8 M in the first year and $16.3 M in the second year. In additional total spending for drugs, this would represent a range of $5.1 M and $6.0 M in state General Fund dollars and $8.7 M and $10.3 M in federal funds for each year, respectively.

Medicaid is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 62%. Administrative expenditures are generally matched at 50%.

Explanation of State Revenues: (Revised) *Additional Drug Rebates:* Additional drug purchases in the fee-for-service system would have offsetting drug rebate revenue associated. The actuarial estimates discussed above are net cost estimates; they include the impact of increased rebates. The federal government participates in the rebate revenue at the same matching percentage used for claims, or approximately 62%.

See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Family and Social Services Administration, Indiana Prescription Drug Program, and the Office of Medicaid Policy and Planning,.

Local Agencies Affected:

Information Sources: Office of Medicaid Policy and Planning,

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